WIC-14b
Rev. 5/05

DATE OF REQUEST:_____

KENTUCKY WIC PROGRAM DRUG STORE APPLICATION

Please Print unless otherwise indicated.

ALL QUESTIONS ON THE APPLICATION MUST BE PROPERLY AND FULLY COMPLETED. PLEASE REVIEW THE WIC INFORMATION MANUAL FOR PROSPECTIVE DRUG STORES FOR INSTRUCTIONS ON COMPLETING THIS FORM.

1. STORE NAME _____

2. **PHYSICAL STORE ADDRESS:**

   STREET # _____ STREET NAME _____

   CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

3. **MAILING ADDRESS (Do not complete if mail can be delivered to the store's physical location.):**

   STREET # _____ STREET NAME _____

   RURAL ROUTE NUMBER/P.O. BOX _____

   CITY _____ STATE _____ ZIP CODE _____

4. **STORE TELEPHONE NUMBER:** (_____) _____
   Area Code Number

5. **TYPE OF OWNERSHIP (Check One):** ☐ Single Owner ☐ Partnership ☐ Corporation

6. **OWNERSHIP INFORMATION:**

   A. **CORPORATION NAME AND ADDRESS (For any business that is incorporated):**

   CONTACT PERSON: _____, _____ TITLE: _____
   Last Name First Name

   BUSINESS NAME: _____

   STREET#/NAME: _____

   P.O. BOX: _____

   CITY: _____ STATE: _____ ZIP CODE: _____

   TELEPHONE NUMBER: (_____) _____
   Area Code Number

Kentucky
UNBRIDLED SPIRIT

14. a. Are you authorized to accept Food Stamps? ☐Yes ☐ No
If yes, Food Stamp Authorization Number: _____

b. Are you a Medicaid provider? ☐Yes ☐ No
If yes, Medicaid Provider Number: _____

15. Including this store, have you (Applicant, the corporation or manager) ever owned or managed a firm which violated the Food Stamp regulations, received a warning letter or was withdrawn, disqualified, assessed a civil money penalty or fined? ☐Yes ☐ No
If yes, specify the date, the reason, and identify the person(s) or corporation, the store name and location involved.

Date: _____ Reason: _____

Name of Store: _____

Person(s)/Corporation: _____

Address: _____

16. Has the Owner, corporation or manager ever had a license denied, withdrawn, suspended or been fined for license violations (i.e., business or health licenses)? ☐Yes ☐ No
If yes, list the type of license, the reason for and date of denial, fine, suspension, withdrawal or disqualification.
Type of License: _____ Reason: _____ Date: _____

17. BUSINESS ETHICS: Are any of the following now charged with or have they ever been convicted of or had a civil judgment for fraud; antitrust violation; embezzlement, theft or forgery; bribery; falsification or destruction of records; making false statements or claims; receiving stolen property; or obstruction of justice: 1) any partner, 2) owner, 3) any officer, 4) the corporate entity, 5) the manager, or 6) any stockholder who has a substantial role in the operation of the store? **If yes**, attach a written explanation, giving the name of the person(s) charged or convicted and their relationship to the owner, partner or corporate entity, and their current or past position, if any, in the store or corporation; the court and court docket number, the crime(s) and date(s) committed; the penalty and time served, and any other relevant information.

18. List the wholesaler/retailer(s) that you expect to use for the purchase of infant formula:_____
Infant formula must be purchased from the list of infant formula wholesalers, distributors and retailers licensed in Kentucky or formula manufacturers registered with the FDA. An approved list is available from the State Agency or on-line at http://chfs.ky.gov/dph/ach/wic.htm.

19. Indicate the number of cash registers: _____

Do any of these cash registers have optical scanners? ☐Yes ☐ No

20. IS THIS STORE OPEN YEAR-ROUND? ☐Yes ☐ No
If NO, check the months when the store is OPEN:

☐ January	☐ April	☐ July	☐ October
☐ February	☐ May	☐ August	☐ November
☐ March	☐ June	☐ September	☐ December

21. HOURS OF BUSINESS:

Monday	___ A.M.	to	___ P.M.
Tuesday	___ A.M.	to	___ P.M.
Wednesday	___ A.M.	to	___ P.M.
Thursday	___ A.M.	to	___ P.M.
Friday	___ A.M.	to	___ P.M.
Saturday	___ A.M.	to	___ P.M.
Sunday	___ A.M.	to	___ P.M.

5. Comments: _____

_____

_____

I CERTIFY THAT I HAVE VISITED THIS DRUG STORE AND FIND IT (☐ ELIGIBLE / ☐ NOT ELIGIBLE) BASED UPON THE CRITERIA FOR SELECTION OF VENDORS AND THE VENDOR AGREEMENT. IF THIS VENDOR IS NOT ELIGIBLE, PLEASE DOCUMENT WHY:

SIGNATURE OF LOCAL AGENCY _____ DATE: _____

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STATE AGENCY USE ONLY

1. Date Food Stamp information verified: _____ Food Stamp Number: _____
   Date Medicaid Provider Number verified: _____ Medicaid Provider Number: _____

2. Does the drug store meet the Criteria? ☐Yes ☐ No
   If no, explain: _____

   _____

   _____

3. Recommended for approval? ☐Yes ☐ No

4. Additional Comments: _____

_____

_____

5. Signature _____ Date _____